

Case Number:	CM15-0009176		
Date Assigned:	01/27/2015	Date of Injury:	01/10/2012
Decision Date:	03/26/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/15/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a year old female, who sustained an industrial injury on 01/10/2012. On provider visit dated 01/07/2015, the injured worker has reported right hip pain and lumbar spine. On examination she was noted to have decreased range of motion of right hip and lumbar spine was noted to have tenderness to the right S1 joint. She was noted to have a slight limp and ambulated with the assist of a cane. The diagnoses have included status post right total hip arthroplasty and right knee contusion. Treatment plan included Voltaren Gel 1%, continued physical therapy and MRI lumbar spine with contrast. On 01/15/2015 Utilization Review non-certified Voltaren Gel 1%, continued physical therapy and MRI lumbar spine with contrast. The CA MTUS, ACOEM, Chronic Pain Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

MRI of the Lumbar Spine L2-S1 with Contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: According to CA MTUS/(ACOEM), 2nd edition (2004), page 303, Low Back Complaints, Chapter 12, which is part of the California Medical Treatment Utilization Schedule. It states, "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." In this particular patient there is no indication of criteria for an MRI based upon physician documentation or physical examination findings from 1/7/15. There is no documentation nerve root dysfunction or failure of a treatment program such as physical therapy. Therefore the request of the MRI of the lumbar spine is not medically necessary and appropriate and is non-certified.

Voltaren Gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 111-112.

Decision rationale: CA MTUS/Chronic Pain Medical Treatment Guidelines, page 111-112, NSAIDs, states that Voltaren Gel is, "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity)." In this case there is insufficient evidence of osteoarthritis in the records from 1/7/15 to warrant Voltaren Gel. Therefore determination is for non-certification.

Continued Physical Therapy (unspecified frequency and body part): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 23.

Decision rationale: Per the CA MTUS Post surgical guidelines, Synovectomy, page 23, 14 visits are authorized over 3 months. In this case there is lack of functional improvement to support further visits per the exam note of 1/7/15. Therefore the determination is for non-certification.